STATE OF WISCONSIN
BEFORE THE VETERINARY EXAMINING BOARD

IN THE MATTER OF THE REQUEST FOR SUMMARY SUSPENSION OF THE VETERINARY LICENSE OF: JEAN M. ELMER, D.V.M., RESPONDENT.	ORDER FOR SUMMARY SUSPENSION ORDER:174899

Wisconsin Veterinary Examining Board Case Nos. 24 VET 107, 24 VET 146, 25 VET 081 and 26 VET 022

The State of Wisconsin, Veterinary Examining Board (Board), having reviewed the Petition Seeking Summary Suspension of Respondent's license, and it appearing based on the Petition that public health, safety, or welfare imperatively requires emergency action, makes the following Findings of Fact, Conclusions of Law, and Order of Summary Suspension.

PARTIES

1. The Veterinary Examining Board (Board), P.O. Box 8911, Madison Wisconsin, 53708-8911.

2. The Division of Animal Health (DAH), within the Department of Agriculture, Trade and Consumer Protection (Department), 2811 Agriculture Drive, Madison Wisconsin, 53718.

3. Dr. Jean M. Elmer, D.V.M. (Respondent), is licensed in the State of Wisconsin to practice veterinary medicine, practicing under license number 409939, current through December 31, 2027. The most recent address on file with Department for Respondent is 10902 Eckel Road, Blue Mounds, WI 53517.

NOTICE

4. In accordance with Wis. Admin. Code § VE 3.62(1), on March 30, 2026, Respondent was provided the Notice of Petition (Notice) and Petition Seeking Summary Suspension (Petition) via USPS mail, including the time and place when the Petition would be presented to the Board (April 14, 2026, at 1:00 p.m. via Teams, link provided). Per Wis. Admin. Code § VE 3.58, notice by mail is complete upon mailing. The Respondent was also sent the Notice and Petition via email to Respondent's legal counsel at jmw@wbattys.com.

FINDINGS OF FACT

5. On August 30, 2024, the Board received a complaint against the Respondent regarding Respondent's unsterile surgical procedures, use of expired medications, unlicensed staff administering rabies vaccinations, and inadequate ambient temperature controls in the clinic.

6. On September 4, 2024, Board Investigator Erin Carter (Carter) spoke with Complainant, Dylan Goossen (D.G.), a former employee at SVC. Complainant worked at SVC for six (6) years ending in August 2024. D.G. made the following allegations:

a. Respondent saved unused suture material and used it to close incisions for farm cat surgeries. Respondent placed unused suture material in a stainless steel container with a lid, kept in the surgery room. The suture material and container were not autoclaved or otherwise sterilized at any point.
b. The amounts of controlled substances used on or dispensed to a patient are not recorded in the patient's medical record.
c. SVC has an air conditioning unit, but Respondent states it does not function properly and on very hot days in the summer, the temperature inside SVC has adverse effects on surgical patients' body temperatures and recovery time.
d. SVC does not employ any certified veterinary technicians (CVT). Unlicensed assistants administer rabies vaccinations when Respondent is not at the clinic and sign Respondent's name to rabies vaccination certificates.

7. On September 17, 2024, Carter spoke with Luna Franzmann (L.F.), a current SVC employee of two years. L.F. stated the following:

a. Unused suture material is stored in a metal tin and used for farm cat surgeries. L.F. states that sometimes there was still blood on the suture material and the tin or suture material were not cleaned or autoclaved.
b. Unlicensed assistants intubate and monitor patients during surgery and adjust isoflurane as needed. Unlicensed assistants adjust based on their assessments with only occasional, limited direction from Respondent.
c. Respondent does not consistently record the amounts of controlled substances used or dispensed in patients' medical records or the controlled substance log. L.F. provided a specific example of an in-home euthanasia performed on a cat, "Lucky" in which no dose of euthasol had been recorded in the medical record or the controlled substance log.
d. Respondent does not create complete records for farm calls. L.F. provided a specific example of a certificate of veterinary inspection (CVI) issued to a horse, "Queso", whose medical record did not contain any exam findings on which to base the issuance of the CVI.

e. Respondent was out of the office for a total of two to three weeks during 2024. Surgeries were cancelled, but unlicensed assistants saw patients, diagnosed illnesses, prescribed treatments, administered rabies vaccinations, and issued CVIs. L.F. recalled three (3) specific dates on which Respondent was not in the clinic, but unlicensed assistants conducted patient appointments.
    i. On August 20, 2024, unlicensed assistants examined a cat who was continually shaking its head. Respondent had performed an auricular hematoma repair surgery previously. Assistants scheduled revision surgery later to be performed by Respondent.
    ii. On August 22, 2024, unlicensed assistants performed a new puppy exam and administered a distemper combination vaccination.
    iii. On August 22, 2024, unlicensed assistants examined a dog for a CVI. The assistants wrote the CVI and signed Respondent's name.
    iv. On August 22, 2024, unlicensed assistants administered rabies and distemper vaccinations to a dog, "Remi". L.F. examined Remi's paw and dispensed Animax.

f. L.F. recalls a week of very hot weather in August 2024. SVC has an air conditioning unit but it is broken and Respondent will not fix it. On August 26, 2024, L.F. took temperatures of patients for every surgical patient as she was concerned about their recovery in the hot weather and it was over 80 degrees Fahrenheit inside the clinic. Assistants were removing dogs from their enclosures, placing them on wet towels on the floor, administering subcutaneous fluids, and using fans brought from their homes. L.F. provided a specific example for a patient named "Madeira":
    i. Temperature at arrival, 9:36 a.m. was 101.2 degrees F
    ii. Temperature pre-surgery was 103.4 degrees F
    iii. Temperature during surgery was 104.2 degrees F
    iv. Temperature post-surgery was 104.9 degrees F. At this point the dog was "panting and struggling".
    v. Temperature at discharge was 103.5 degrees F.
g. L.F. has observed flies in the surgery room and maggots in the trash. An open trash can containing feces and surgical waste located under the surgical table is emptied, at most, every other day.
h. If Respondent needs a tool or is running low and there is not one that has been autoclaved, she will tell the assistants to "go grab her something from the sink". L.F. said she scrubs instruments before autoclaving, but instruments in the sink haven't been autoclaved.

i. Respondent does not wear gloves for dentals, only for spays and mass removals.
j. SVC does not have a working washer and dryer. The washer does not wash things thoroughly and items must be hung up to dry.
k. Respondent attempted to administer 3 Liters of IV fluids over two-and-a-half (2.5) hours to a dying dog, "Bo" Bradfield.

8. On September 30, 2024, Carter received a written statement from D. G. detailing his job duties while previously employed at SVC.

9. On November 4, 2024, Carter conducted an unannounced inspection of SVC along with two Diversion Investigators from the Drug Enforcement Agency (DEA).

10. During the inspection, Carter made the following observations regarding clinic sanitation:

a. The walls in the surgery room were visibly soiled.
b. Multiple walls within the treatment room were visibly soiled, with smeared mud around the door leading to the hallway.
c. There was extreme accumulation of mud smearing around the door from the backroom to the procedure room. Based on appearance, this wall has not been cleaned for several weeks.
d. Staff stated that dogs sleep in the boarding building in kennels with sand substrate. Dogs come through the clinic from the boarding building to access the exercise area attached to the clinic in muddy, wet, sandy condition. Staff are not aware of any cleaning protocol which requires cleaning the walls/door in the backroom or treatment areas.
e. A toothbrush stored out in the open in the surgery room is used for all dentals, according to staff, and is not autoclaved or sterilized between uses.
f. A stainless-steel container holding pieces of suture material and curved needles was in the surgical room drawer along with other items. The container's cover was not secured.
g. The garbage can beneath the procedure table was nearly full. Staff informed me that the last time surgeries were performed was on Friday, November 1, 2024. Garbage cans are emptied every other Tuesday as garbage pick-up is every other Wednesday.
h. There is a washer and dryer at SVC. The washing machine had a load of laundry inside but had not been started. There was accumulated dust, sand, and other debris in the dispensers and in corners beneath the lid. The dryer had a variety of items stacked on top which made it difficult to reach the controls. There was no laundry in the dryer.
i. "Staff member" reported that the washing machine runs but does not clean anything that's run through it; items come out still dirty. It gets laundry wet but does not thoroughly clean it. The dryer works, but

> Respondent reportedly does not allow the use of the dryer. Laundry is hung upstairs and gets dirtier. The dryer heats the blankets, and if it is used, it takes a long time to fully dry blankets. Staff stated that Respondent has not mentioned replacing or fixing the washing machine or dryer.

11. Carter requested a list of patient records, photographed controlled substance logs (Alprazolam 2 mg tablets, Butorphanol injectable solution, 10 mg/mL, Diazepam Injectable 5mg/mL, Ketamine Injectable 100 mg/mL, and Euthanasia injectable), and three (3) CVIs. The SVC receptionist informed Carter that the computerized record keeping system was down and that she would email the requested records once the computer was fixed.

12. The DEA Diversion Investigators spoke with Respondent and did not find any violations.

13. Respondent told Carter that she had been out of the clinic for extended periods over the past year due to health issues. She [redacted] and was out from April 30 to June 1 [2024] for surgery and recovery but was available by phone and had instructed her employees, D.G. and L.F., to call her or use Zoom whenever necessary. Respondent further stated that she had also come into the clinic in a wheelchair and sat in the exam room door to do what work she could during this time.

14. Respondent stated she was also out for another medical issue later in the year and instructed the employees again to call her or use Zoom whenever necessary. She did not receive any phone calls or Zoom calls. Employees had access to controlled substances when she was out. To her knowledge, phenobarbital was the only controlled substance dispensed. Respondent stated she knew D.G. and L.F. were cleaning ears and dispensing medications. Respondent stated that in hindsight, she should have just closed the clinic.

15. On November 5, 2024, Carter received via email from "staff member" the records requested during the inspection:

a. Farm cat neuter and spay medical records (Orange Kitten Ranum, Lewis Donnell, Winston Donnell, and Black Meyer).
b. Controlled substance log medical records check (Lucy O'Connell, Coco Raymond).
c. August 20, 2024, appointment schedule.
d. August 22, 2024, appointment schedule.
e. August 26, 2024, appointment schedule.
f. Maggie Dahm medical record.
g. Cabali medical record and CVI.
h. Remi Hoffmaster medical record and rabies certificate.
i. Tots Botham medical record.

j. Madeira Hoffman surgical record.
k. Lucky Schlimgen medical record.
l. Queso Wells medical record for CVI issued September 28, 2023.
m. Bo Bradfield medical record.
n. Cyrus Bindle medical record.

16. The email also noted that Respondent had not been in the clinic from August 19, 2024 to August 23, 2024. All appointments on those days were performed by assistants.

17. On November 5, 2024, Carter also received a text stating "doc has been making changes to records from the list you gave me yesterday."

18. On November 6, 2024, Carter received an additional email from "staff member" with three (3) attached rabies vaccination certificates**.** The signatures vary in appearance among the certificates. The email also stated that Respondent made changes to requested medical records for farm cat spay and neuter records as well as records selected to verify that controlled substances were recorded in both the controlled substance logs and the individual patient's medical record. "Staff member" did not have copies of the records before changes were made and stated the following changes were made:

a. For a dog "Cabali" seen at SVC on August 22, 2024, Respondent added notes for the CVI that she was contacted by telephone. Respondent was not in the clinic that day. The signature on the CVI differs significantly from Respondent's signature on documents received by the VEB previously.
b. For a dog "Remi" seen at SVC on August 22, 2024, and given a vaccination against rabies, Respondent added notes that she was contacted via phone call and she was not; the entire appointment was performed by L.F. and D.G.

19. On November 6, 2024, Carter received an anonymous email stating, "There was also another dog that had a mass on its butt and if it wasn't wrapped, it would bleed a lot. [Respondent] was going to start surgery so she sedated the animal and unwrapped the bandage to take a look at it but got distracted by other things happening at the clinic for an hour. She did not wrap the dog back up and put him in a kennel, so he continued to bleed all over the treatment area. [The patient's name was "Duke"]. The email included attachments of the patient's medical record and a video of Duke walking around while blood drips on the floor of the clinic.

20. This email also stated that Respondent does not clean the [rectal] thermometer after using it on a patient.

21. On November 25, 2024, Carter sent an email to Respondent's attorney to request the exact dates Respondent had been out of the clinic "later in the year" as stated at the November 4, 2025, clinic inspection.

22. On December 3, 2024, Respondent's attorney stated Respondent had been out of the office August 19, 2024, until August 21, 2024.

23. Carter sent an email to anonymous requesting any information that would support D.G's and L.F's statements that Respondent had been out of the office August 19, 2024, to August 23, 2024.

24. Carter spoke with P.B., whose puppy, "Tots", had been seen at SVC on August 22, 2024. P.B. stated it was Tots' first visit to SVC, and it was for vaccinations. P.B. had not seen Respondent and the visit had been performed by a "technician".

a. On December 5, 2024, P.B. sent an email confirming statements made during the phone conversation.

25. On December 4, 2024, Carter received emails from anonymous with several photographs of appointment details, such as appointment schedules and patient histories, from August 19, 2024, to August 23, 2024. The email also included the following statement: "I have pictures of every single appointment from that week showing none of the initials are hers except one that [anonymous] entered and forgot to put my initials in instead. You can see that all surgeries or euthanasia's were cancelled or rescheduled."

a. Appointment schedules for August 22, 2024, and August 23, 2024, showed all surgeries cancelled but other appointments for cats and dogs remained on the schedule.

26. On December 6, 2024, Carter spoke with Lisa Aumann, (L.A.), whose dog, "Mazie", was seen at SVC on August 23, 2024. According to Mazie's medical records, Sucralfate and Loperamide were dispensed. L.A. consulted her records and stated that Respondent had not been at SVC that day, and that she had been charged a "tech office call".

a. On December 11, 2024, L.A. sent an email confirming statements made during the phone conversation.

27. On December 6, 2024, Carter spoke with Danielle Hoffmaster (D.H.), whose dog "Remi" had been seen at SVC on August 22, 2024, for a rabies vaccination. D.H. stated she had not seen Respondent at that appointment. Carter requested a text or email with this information in writing but did not receive it.

28. On December 10, 2024, Carter spoke with Ashley Pratt (A.P.), a foster provider for Fetch Wisconsin Rescue's dog, "Cabali", seen at SVC on August 22, 2024, and issued a CVI. A.P. stated she and Cabali were taken to the exam room where D.G. performed a brief physical exam. A.P. then went back to the waiting room. A.P. said she wasn't sure who signed the CVI, but says there was another staff member at the clinic, though she doesn't recall her name. A.P. said she had looked up a picture of Respondent on the SVC website and was "fairly confident" she had never seen her before.

a. A.P. sent an email confirming statements made during the phone conversation.

29. Carter received additional SVC medical records via email from anonymous which anonymous felt demonstrated substandard care by Respondent.

a. SVC medical record for a cat, "Monkey", shows Monkey was spayed by Respondent on December 7, 2024. Anonymous states Monkey was placed in a kennel with her two (2) kittens. Respondent does heat the clinic but it is still cold inside, making it difficult for surgery patients to regulate body temperature. Respondent checked on Monkey three (3) times visually but did not do full post-surgical monitoring to check temperature and heart rate. The third time Respondent checked on Monkey she was deceased.
b. In a follow-up email on December 16, 2024, anonymous stated that no warming equipment is used during or after surgery. In colder months, patients are wrapped in blankets but they don't always stay wrapped.

30. On April 11, 2025, Respondent supplied a written response and supporting documentation. Carter received the following records:

a. D.G. spot check of controlled substances inventory from November 9, 2022 (in reference to allegation 4 of the complaint).
b. Madeira Hoffmaster's medical record (in reference to allegation 4 of the complaint).
c. Calf Gomez medical record (in reference to allegation 6 of the complaint).
d. Cabali medical record (in reference to allegation 7 of the complaint)
e. Maggie Dahm medical record (in reference to allegation 7 of the complaint).
f. Remi Hoffmaster medical record (in reference to allegation 7 of the complaint).
g. Tots Botham medical record (in reference to allegation 7 of the complaint).

h. Bo Bradfield medical record (in reference to allegation 9 of the complaint).
i. Plumb's ketoconazole monograph (in reference to allegation 9 of the complaint).

31. Respondent's April 11, 2025, response states: "On the few occasions where suture material opened during a patient's surgery is not completely used up, the remainder is cold sterilized by soaking in chlorhexidine for 4-6 hours… [Respondent] will use the cold-sterilized suture material if an extra stitch or two is needed to complete closures for spay surgeries on barn cats."

32. The response further states: "[D.G.] contends that [Respondent] does not record the doses of controlled substances used on farm calls or at-home humane euthanasia in patient records…Those allegations are similar to those in the anonymous complaint against [Respondent] in 23 VET 111. In that case, you [Carter] performed an unannounced inspection of SVC on February 1, 2024, but did not have any concerns related to SVC's controlled substances safe or log. Rather, you [Carter] found that two patient veterinary records did not match SVC's controlled substances log. [Respondent] adjusted her recordkeeping protocols and completed continuing education on the topic of recordkeeping. Since then, [Respondent] has ensured that patient records, including those of farm, fiber, and equine patients, reflect the names and amounts of controlled substances prescribed, dispensed, or administered."

33. The response also states:
a. "As an initial matter, the AC unit runs smoothly and performs as expected. No repair or replacement is required."
b. "As for surgical patients, [D.G.] did not assist [Respondent] in any surgeries after April 30, 2024, and did not measure a patient's temperature unless [Respondent] specifically asked him to. [D.G.'s] broad allegations about unidentified patient temperatures are therefore suspicious and likely based on inadmissible hearsay."
c. "Moreover, the allegations do not contain sufficient detail to allow [Respondent] to identify patients not specifically named. [Respondent] can comment only generally about environmental and body temperature in the context of surgery for unidentified patients."
d. "Animals in surgery and recovering from anesthesia are at frequent risk for hypothermia and therefore, contrary to [D.G.'s] implication, require elevated environmental temperatures (typically 81-84o F) or heat aids (e.g. heating pad or hot water bottle) to ensure normal body temperature. Conversely, hyperthermia is much less common during anesthesia and is generally caused by excessive warming, drug reactions

(e.g. opioid-induced hyperthermia in cats), illness causing prexia, or the rare genetic condition malignant hyperthermia."

e. "When environmental temperatures reach 84-90o F, SVC's windows are opened. Because SVC is on a hill in Blue Mounds, simply opening the windows provides a significant amount of good ventilation."
f. "When environmental temperatures reach or exceed 90o F, the AC is turned on. All veterinary staff are trained on SVC's policy that any patient whose body temperature reaches 103o F or higher is cooled with a fan, receives room temperature subcutaneous fluids, and has a cool, wet towel laid over them. SVC has a stock of fans for that purpose. [Respondent] made the cooling procedures a matter of clinic protocol and trained veterinary assistants on them so that they could be implemented quickly without extensive discussion."

34. The response states:
    a. "All SVC veterinary assistants are trained to give vaccines under [Respondent's] direct supervision."
    b. "When [Respondent] was not in the clinic, SVC assistants were trained to contact her via Zoom or video call so that [Respondent] could visually assess the patient, speak with the client, and provide direction to the veterinary assistant."
    c. "SVC assistants were trained to administer rabies vaccines only if [Respondent] was physically in the examination room supervising the assistant and speaking with the client."
    d. "Before receiving this complaint, [Respondent] was unaware that Wis. Stat. § 95.21(2)(a) limits rabies administration to veterinarians and to CVTs when a veterinarian is physically present at the location where the vaccine is administered. [Respondent] was also previously unaware that under Wis. Admin. Code § VE 1.44(8)(a), unlicensed assistants can administer vaccines only when the veterinarian is personally present on the premises where the vaccine is administered. [Respondent] acknowledges that her previous practice of delegating rabies vaccine administration to assistants under her direct supervision and of delegating other vaccine administration to assistants under her direct telehealth supervision were not in line state with law. Those practices have ceased.
    e. Now, [Respondent] now administers all rabies vaccines herself and trained SVC staff to administer other vaccines only be when she is at the clinic."

35. Response further states: "[D.G.'s] allegation that [Respondent] does not

keep records for "farm calls" is erroneous. [Respondent] maintains records for food, fiber, and equine patients as required by Wis. Admin. Code § VE 1.52."

36. Response also states:
    a. "[Respondent] occasionally asks an assistant to intubate a patient under her direct supervision… [Respondent] is also physically present in the operating room and standing right next to the assistant when the patient is intubated. Intubation is not the diagnosis or prognosis of disease or the prescription of drugs or treatments…It is not surgery since patient tissue is not penetrated or severed…Intubation is not a veterinary medical act that may only be delegated to CVTs…Therefore, intubation is a nonsurgical treatment that may be performed by an unlicensed assistant under the supervision of a veterinarian that is personally present on the premises where intubation is performed… Because [Respondent] is not only on the premises but maintains direct supervision of the assistant that intubates a patient, [Respondent's] delegation of that act is lawful."
    b. "[Respondent] monitors a patient's anesthesia herself during surgery; assistants provide appropriate help as requested by [Respondent] so that she does not have to break the sterile field. Assistants thus sometimes observe anesthesia parameters simultaneously with [Respondent]. If some aspect of the anesthesia needs to be adjusted, [Respondent] directs the surgical assistant(s) to take the exact action needed. [Respondent] does not allow unlicensed assistants to unilaterally adjust anesthesia parameters. [Respondent] is not aware of any patient experiencing adverse events or complications as the result of an unlicensed assistant, as opposed to a CVT, alerting her to a change in patient physiologic variables or adjusting anesthesia parameters pursuant her specific direction. While it may be best practice to have a CVT monitor anesthesia while [Respondent] operates, [Respondent] has not found suitable applicants for hire despite actively searching. Wisconsin Statutes and Chapter VE of the Wisconsin Administrative Code do not define "administer anesthesia," "induce anesthesia," or "monitor anesthesia." It is [Respondent's] position that neither situation discussed *supra* – allowing an experienced assistant to intubate a patient under [Respondent's] direct supervision and guidance, and to provide supplemental observation of a patient's vital parameters along with [Respondent]– contravenes Wis. Admin. Code § VE 1.44(6)(a)."

37. Response states:

a. [D.G.] alleges that during [Respondent's] subsequent medical leave for a potential [redacted] issue, all surgeries on August 20, 2024, were cancelled but one appointment was not…[Respondent] believes that the allegation refers to "Maggie" [Dahm]… According to the patient record, Maggie was presented to SVC on August 20, 2024, … for a "tech office call." The patient record does not identify the presenting complaint, or what part(s) of Maggie's body were being examined. [Respondent] does not recall receiving a video call from the assistant during that appointment, such that a virtual examination would be permissible under Wis. Admin. Code § VE 1.50(4). That fact, along with the lack of detail in the patient record, leads [Respondent] to believe that this was another instance of an SVC assistant conducting evaluating a patient without her knowledge or authorization."
b. [D.G.] inaccurately asserts that [Respondent] was on medical leave on August 22, 2024, and that all surgeries were cancelled. However, [Respondent] had returned to SVC the day before. [D.G.] alleges that an assistant "performed" a "new puppy wellness" appointment and administered a vaccination. After reviewing SVC patient records, [Respondent] believes that the allegation refers to Tots Botham. Tots … presented to SVC on Thursday, August 22, 2024. The patient record does not identify the presenting complaint or whether Tots was physically examined. [Respondent] was in the clinic that day, but was not aware of or informed about Tots' appointment. Therefore, [Respondent] suspects that the visit occurred either before she arrived at SVC that morning or after she left for the day."
c. [D.G.] alleged that a dog had an "appointment for a CVI" on August 22, 2024 and that assistants examined the dog, as well as wrote and signed the CVI. "[Respondent] believes that the allegation refers to Cabali … presented to SVC on August 22, 2024…[Respondent] was at SVC that day, but Cabali's visit was scheduled for a timeslot prior to [Respondent's] anticipated arrival. An assistant measured Cabali's temperature and heart rate and observed that Cabali was bright, alert, and responsive but scared. The assistant then called [Respondent] to report that information and the lack of any sign of contagious or infectious disease. With that information, [Respondent] determined that a CVI could be issued for Cabali and asked the assistant to sign her name to the CVI. Wis. Admin. Code §§ ATCP 10.06(2) and (4)(i) do not prohibit veterinarians from inspecting animals and prepare CVIs via telehealth technology, nor does the Department or Board have any guidance on that topic. Nonetheless, prior to receiving [the] complaint, [Respondent] did not realize that the Board's telemedicine rule, Wis.

Admin. Code § VE 1.50(4), required establishment of a veterinarian-client-patient-relationship (VCPR) via in-person physical examination before telehealth technology could be utilized. When she did become aware of the requirement, [Respondent] trained SVC staff that CVIs could not be issued via telehealth technology and that she must personally examine the subject animal and prepare and sign their CVI."

d. "[D.G.] alleges that on August 22, 2024, an "[a]ssistant examined the paw" of a dog named "Remy," "dispensed Animax[,]" and administered rabies and "distemper combo" vaccinations." … assistants were trained to video call [Respondent] when she was not in the clinic so that she could visually assess the patient, speak with the client, and provide direction to the assistant. That procedure was followed for the August 22, 2024, appointment of "Remi" Hoffmaster." Remi … presented to SVC on August 22, 2024. The visit was scheduled for a timeslot before [Respondent] was due to arrive at the clinic that morning. An assistant measured Remi's vital signs, which were normal, and reported the information to [Respondent] via a video call. Hoffmaster told [Respondent] that she was concerned there had been some trauma to one of Remi's paws. The assistant held the camera so that [Respondent] could visually examine Remi and inspect the paw. [Respondent] noted only minor irritation on Remi's paw and prescribed Animax ointment. [Respondent] told [D.H.] that Remi was healthy and able to receive vaccinations. [Respondent] instructed the assistant to administer rabies and distemper combination vaccines and watched as the assistant did so… [Respondent's] examination of Remi via video call was permitted under Wis. Admin. Code § VE 1.50(4) as the VCPR had previously been established via in-person physical examination. It was also permissible for [Respondent] to delegate distribution of Animax to an assistant under Wis. Admin. Code § VE 1.44(7)(c) because [Respondent] was actively supervising the assistant via video conference.

38. Response further states: "SVC has a dryer, and both it and the washing machine function properly. Issues arise only when assistants attempt to use the machine improperly, as Goossen did on many occasions. For example, assistants sometimes overfill the drum and/or fail to remove feces from towels before placing them into the washing machine. [Respondent] has had to retrain SVC assistants several times to remove feces before placing items in the washing machine and only filling 3/4 of the drum."

39. Response also states, regarding Complainant's allegation "Respondent

tried to give 3L IV fluids over 2.5 hours to a dying dog": "On September 5, 2024, [LB] presented Bo to SVC after other veterinarians said "Bo had a tumor or a foreign body in his gastrointestinal (GI) tract…[Respondent] offered to keep Bo hospitalized overnight and take a contrast radiograph in the morning….Before leaving SVC for the night, [Respondent] observed that Bo was drooling excessively. That sign was consistent with a possible GI tumor or foreign body."

40. When [Respondent] returned to SVC the next morning, September 6, 2024, she examined Bo and observed that he was now depressed, lethargic, close to 10% dehydrated, and still drooling excessively. An abdominal radiograph was taken, but the contrast agent had passed through the GI tract and did not reveal any additional information. [Respondent] called Bradfield to report on Bo's status and the unsuccessful contrast radiograph. Bradfield consented to intravenous (IV) and subcutaneous fluids and abdominal exploratory surgery to search for and remove any tumor or foreign body. Because Bo was 92 lb. and almost 10% dehydrated, he had a 4-5L fluid deficit. [Respondent] administered 2L of fluids intravenously and 1L subcutaneously over the course of 2.5 hours. Provision of 3L of fluids was indicated and medically appropriate for the large deficit."

41. Respondent provided a copy of Bo Bradfield's medical record to the Investigator.

42. On May 7, 2025, Carter sent an email to L.A. asking if she recalled a video call taking place during Mazie's appointment on August 23, 2024. L.A. replied no, not to her recollection.

43. On May 14, 2025, Carter spoke on the telephone with Amanda Norden (A.N.), whose cat "Ivar" was seen at SVC on August 23, 2024, and, according to records, a CBC was performed and Solensia, Loxicom, and Animax were dispensed. A.N. stated D.G. performed the entire appointment, discussed the findings and dispensed the medications. A. N. stated she did see Respondent at the clinic during the appointment – she popped her head into the exam room to ask what was going on with A.N.'s cat. Then Respondent left the room without a discussion of Ivar's condition.

a. The medical history, previously provided by anonymous in an email sent December 4, 2025 (see par. 25), states A.N. was charged for a tech office call. which indicated on August 23, 2024, Ivar received the following care at SVC: Tech office call, CBC, Loxicom Oral 1.5mg/32ml, Solensia 7mg/ml, Feline Animax Ointment, and hydrolyzed food.

44. During this telephone conversation, A.N. further stated that Ivar was also

seen at SVC on July 1, 2024. D.G. and another assistant handled the appointment and discussed the findings with A.N.

a. The medical history indicates that on July 1, 2024, Ivar received the following care at SVC: Radiographic Study -1 view, Tech office call code, culture and sensitivity, T4 thyroid test, CBC, TMS Sulfamethoxazole/Trimethroprim 960m.

45. During this telephone conversation, A.N. also stated that she had previously been employed at SVC, and she had received an offer to work at SVC again in early May 2025.

46. Carter sent an email to A.N. with follow-up questions to which A.N. replied the same day. A.N. stated the following:

a. She was employed at SVC from March 2019 to January 2022, and "monitored multiple patients under anesthesia, administer [sic] rabies dozens of times and issued CVI's."
b. She "was expected to handle smaller appointments by [herself], such as ear infections, urinalysis, rabies and vaccine appointments along with cytopoint."
c. She quit working at SVC because the "quality of care drastically went downhill", "lack of sterilization used during surgery was very concerning. Such as not wearing a gown, grabbing hemostats and scissors off the wall instead of opening another surgical pack. Seeing sweater sleeves dipping into open wounds and then charging clients when they come back with an infection. Starting the next surgeries before the surgical room could be properly turned over causing cross contamination."
d. "[Respondent] would also leave and not tell anyone, expecting the staff to handle appointments without her and then upsetting clients when they would ask to see her and she was not on-site or getting upset with the staff when we would end up needing her for the appointment."
e. On May 2 [2025] Respondent made an offer of employment to A.N. "[Respondent] was talking about not coming in on May 3 [2025]... Due to there only being a rabies vaccine appointment that day, and [Respondent felt A.N.] could handle the rabies vaccine by [her]self."
f. A.N. is not currently employed at SVC.

47. On November 20, 2024, the Board received a complaint, 24 VET 146, regarding Respondent's February 6, 2024, caesarean section and spay of Complainant's dog, "Little Debbie", while the dog was under the care of a rescue, prior to being adopted by Complainant.

48. Complainant, Suzanne Bogue (S.B.), states that in September 2024, Little Debbie displayed signs of estrus (heat). S.B. contacted Respondent and stated she was told it is common for dogs to still display signs of heat after being spayed and an ovarian remnant was close to impossible.

49. S.B. provided records from Little Debbie's primary veterinarian. On October 10, 2024, S.B. presented Little Debbie for concerns including a swollen vulva and enlarged mammary glands. Little Debbie was treated for a UTI and the treating veterinarian discussed differential diagnoses.

50. October 25, 2024, medical record indicates Little Debbie returned to the primary veterinarian as the symptoms had not completely resolved. Little Debbie was still showing possible signs of heat, such as a swollen vulva and bloody vulvar discharge. The treating veterinarian recommended drawing blood for an ovarian remnant panel.

51. November 9, 2024, medical record indicates Little Debbie returned to the clinic to receive testing including a blood draw. S.B. provided the IDEXX endocrinology report dated November 13, 2024, stating "Anti-Mullerian hormone level is consistent with the presence of ovarian tissue."

52. S.B. provided medical records from University of Wisconsin Veterinary Care (UWVC) which indicated that on December 26, 2024, Little Debbie underwent surgery to remove the ovarian remnant. The medical record states, "An abdominal ultrasound was performed which showed an ovary on the left side of the abdomen." The medical record further states, "Surgery revealed a single ovary on the left side was removed without complication."

53. Respondent's February 6, 2025, response states that she "likely counseled the [rescue] agent about surgical risks but does not remember whether she mentioned ovarian remnant syndrome (ORS) specifically, as none of her prior ovariohysterectomy (OHE) patients had experienced that complication."

54. Response further states that on February 6, 2024, when the caesarean section and OHE were performed, following the delivery of 10 puppies, Respondent "…removed the uterus, uterine horns, and ovaries."

55. Response also states: "[S.B.] alleges that she contacted [Respondent's] "office" and was "told" that an ovarian remnant was almost impossible. But [Complainant] did not speak with [Respondent]. Instead, [S.B.] spoke with an SVC staff member who evidently did not know enough about the situation to accurately answer [S.B.'s] query and who failed to document the conversation in Little Debbie's patient record for [Respondent's} review and follow-up."

56. Respondent provided medical records for care provided to Little Debbie. The records indicate Respondent examined Little Debbie on January 22, 2024, January 25, 2024, February 5, 2024, and performed the surgeries on February 6, 2024. There are no discussions with the rescue agent documented in the records on any of the dates.

57. On September 5, 2025, the Board received a complaint, 25 VET 081, regarding Respondent's August 8, 2025, care of Complainant's, Brandon Russ (B.R.) mother's 10-year-old, male, neutered cat, "KitKat".

58. On August 7, 2025, Complainant, B.R. took KitKat to Respondent at SVC following a visit to an emergency veterinary clinic, Veterinary Emergency Group (VEG), in the early morning hours for symptoms of hypersalivation and potential oral pain. Respondent was KitKat's primary veterinarian and B.R. sought to continue care with Respondent rather than at VEG.

59. B.R. provided an email sent to him from VEG on August 8, 2025, at approximately 4 a.m. stating records were simultaneously being sent to SVC.

60. B.R. also provided KitKat's medical records for August 7-8, 2025, visit to VEG. These medical records included abnormal kidney value readings (increased creatinine and globulin) and hyper-salivation.

61. B.R. stated Respondent did not suggest any additional testing or recommendations. [Respondent] suggested that if necessary, the cat return for further evaluation the following week. … the cat was given intravenous fluids and pain medication and sent home. [Complainant] believes that [Respondent] did not review the previous tests…".

62. B.R. further stated that Respondent arrived at least 15 minutes late for the appointment and did not indicate that she knew anything about KitKat's previous visit to VEG.

63. B.R. also stated that he "eventually got [Respondent] to skim the VEG notes off his phone".

64. B.R. stated he repeatedly asked Respondent to review the VEG notes and do appropriate testing for such issues as panting. B.R. suggested Respondent contact his mother. Respondent "insisted" that nothing could be done without speaking to B.R.'s mother.

65. B.R. called his mother. B.R. states Respondent indicated to his mother that there was nothing significantly wrong, and suggested KitKat return if there were problems.

66. B.R. provided KitKat's August 8, 2025, SVC medical record. Notes from the appointment state: "Kit came in with owners son Brandon for a tender mouth; tpr 100.5 hr; difficult to get as kit was purring; 140 wnl Quiet alert responsive; palpating mouth no pain response; no crackling auscultation of lungs I saw bw from VEG 0.1 increase of BUN not a concern; I spoke w/ Lynn the owner and she declined further diagnostics at that time; Her and I discussed this and our plan was Clavamox BID and 1 injection vit b penciliin today; and when she is back in town on Tues if kit has not improved we will do further diagnostics jmedvm".

67. The August 8, 2025, SVC medical record further states: "SUBJECTIVE SECTION – PROBLEM LIST-Lameness-rear limb".

68. Respondent's October 27, 2025, response states: "Just before the [August 8, 2025] 2 p.m. appointment, [Respondent] was out on a farm call or running an errand and did not have time to review KitKat's medical records that were forwarded at approximately 1:38 p.m. by the emergency veterinary facility that had seen KitKat in Madison. When [Respondent] returned to SVC, [B.R.] stated that Veterinary Emergency Group (VEG) had emailed records from KitKat's visit the previous night. An SVC assistant immediately began looking for the new records, but [B.R.] was able to pull them up more quickly on his phone. [Respondent] reviewed KitKat's VEG records on [B.R.s] phone in the examination room…".

69. The response further states: "[Respondent] was able to quickly see that [B.R.] had presented KitKat to VEG just before midnight on August 7, 2025, with complaints of hypersalivation, oral pain, and facial pain."

70. The response also states: "The [VEG] veterinarian discussed possible oral disease or gastrointestinal disease as causes of KitKat's nonspecific clinical signs and offered blood work or radiographs as abbreviated diagnostics. [B.R.] elected blood work only, which showed slightly elevated kidney values."

71. The response states: "The VEG veterinarian recommended a recheck examination in 24-48 hours with KitKat's primary veterinarian "for any additional diagnostics" that "may be indicated." [Complainant's] discharge instructions recommended "rechecking KitKat's kidney values with your primary veterinarian to monitor trends in these values long-term."

72. The response further states: "[Respondent] performed a complete physical examination of KitKat but did not elicit any significant findings. KitKat was bright, alert, responsive, purring, and afebrile; his heart rate, respiratory rate, and respiratory effort were within normal limits. KitKat was not panting, open-mouth breathing, or hypersalivating. [Respondent] did not auscultate any crackling in KitKat's lungs and was unable to elicit a pain response on palpation of the mouth and face. [Respondent] did not observe any obvious signs of infection in KitKat's mouth."

73. The response also states: "[B.R.] pushed [Respondent] to perform additional diagnostic procedures based on the statement in VEG's discharge instructions that "We recommend follow up with your primary veterinarian within 24-48 hours for recheck exam, recheck bloodwork and/or additional diagnostics (radiographs, dental radiographs, etc). Additional treatments may be indicated at this time." However, the Board will recognize the statement as a catch-all provision given the lack of conclusive findings at VEG; it was not an order directing subsequent veterinarians to perform the diagnostics suggested."

74. The response indicates that during a phone call to KitKat's owner, B.R.'s mother, Respondent relayed the results of KitKat's exam and offered to take dental radiographs, administer 50 mL of subcutaneous fluids due to slightly elevated kidney values on the VEG blood work, an injection of the antiemetic Cerenia, prescribe Purina CN Critical Nutrition food, prescribe liquid Clavamox, and administer a small injection of penicillin and vitamin b.

75. The response further indicates that B.R.'s mother consented to antibiotics, penicillin/vitamin b injection, subcutaneous fluids, Cerenia, and prescription food. She declined dental radiographs.

76. The response also indicates that Respondent told B.R.'s mother that they could pursue further diagnostics when she returned home if KitKat had not improved. Respondent directed B.R. to monitor KitKat for worsening clinical signs.

77. Respondent provided KitKat's SVC medical records. August 8, 2025, medical record states: "SUBJECTIVE SECTION' with no further notations.

78. On August 8, 2025, following the appointment with Respondent, B.R. returned to VEG with KitKat as he had been wobbly throughout the day, had not wanted to use the litterbox, and then later showed increased respiratory rate and effort.

79. August 8-9, 2025, VEG records provided by B.R. indicate that KitKat was placed on supplemental oxygen. His condition continued to deteriorate. Complainant elected euthanasia.

80. August 8-9, 2025, VEG records state: "INTAKE EXAM/DIAGNOSTICS: POCUS [Point of Care Ultrasound): TNTC [Too numerous to count] to coalescing B-lines bilaterally; scant pleural effusion bilaterally".

81. August 8-9, 2025, VEG records further indicate the differential diagnoses considered for KitKat's symptoms included: "Chronic Heart Failure (CHF) vs. primary pulmonary disease vs. neoplasia vs. other".

82. On August 11, 2025, VEG provided medical records from KitKat's August 8, 2025, visit to Respondent as KitKat's primary veterinarian.

83. Respondent's October 27, 2025, response states: "Without a necropsy, [Respondent] cannot comment on the cause of KitKat's sudden decline other than to speculate that KitKat may have had a hidden heart condition that suddenly progressed to CHF or he may have aspirated the prescribed Clavamox liquid and developed pneumonia. Both CHF and pneumonia are consistent with respiratory distress and pulmonary edema. As the Board knows, heart disease can advance to CHF at any time without clinical signs. If KitKat did have occult heart disease, he did not exhibit any indicative signs on the afternoon of August 8, 2025, that would have led [Respondent] to recommend cardiac diagnostics such as thoracic radiographs or echocardiogram. Similarly, the VEG veterinarian did not have any concerns about KitKat's respiratory rate and effort in the late evening of August 7, 2025. Therefore, [Respondent] suspects that pneumonia following aspiration of liquid Clavamox may be the more likely cause of KitKat's deterioration. In that case, even if [B.R.'s mother] had consented to radiographs and other diagnostics at SVC, they would not have revealed evidence of aspiration because Clavamox had not yet been prescribed or administered."

84. Response further states: "[Respondent] performed a thorough physical examination, carefully reviewed KitKat's prior medical records, offered appropriate diagnostic procedures, and recommended suitable treatments for mildly elevated kidney values and possible infection."

85. On March 2, 2026, the Board received a complaint, 26 VET 022, regarding Respondent's February 27, 2026, emergency care provided to Complainant, Jessica Wright's (J.W.), six-year-old, male, cat with a suspected urinary blockage.

86. The complaint states: "*On 2-27-26 I brought my cat, Gilbert, to Starlight Veterinary Clinic for a second urinary blockage. I have been a client of this clinic previously, about 3 years ago, but the standard of care I received on this date was fundamentally different from my previous experiences. 1. Lack of Informed Consent and Documentation: Upon arrival, I was immediately taken to the procedure room. No paperwork was presented for my review or signature, no treatment plan was discussed, and no estimates of costs or risks were provided. The veterinarian began administering treatments and procedures without obtaining informed consent. 2. Safety Violations: During the procedure, the veterinarian required me?a non-medical client?to hold the anesthesia induction mask on my cat?s face. I received no instruction, training, or protective equipment. As a result, I was exposed to the anesthetic agent, which I could smell and taste. I believe this constitutes a major safety hazard and a failure to maintain proper staffing and oversight during an anesthetic event. 3. Improper Procedural Conduct: The veterinarian attempted to catheterize my cat while he was clearly in distress and responsive, despite the anesthesia. The procedure resulted in excessive bleeding and appeared to be performed without the necessary support staff to manage the patient?s pain or stability. 4. Unethical Conduct: When the procedure failed, the veterinarian suggested that I take my cat to another facility. When I requested euthanasia, the veterinarian actively discouraged this, repeatedly*

pressuring me to surrender my cat to her. She wanted to remove his penis and keep him for her personal "farm". This pressure was manipulative and highly unprofessional, particularly given the cat?s history as an indoor pet and the surgeon?s own prognosis of future incontinence. 5. Lack of Aftercare Information: Following the decision to euthanize, I was provided with no information regarding cremation options, timelines, or procedures. Due to the high-stress environment, I felt forced to leave without receiving these standard arrangements. When I had called today and asked where he was being sent for cremation the receptionist told me she is not an employee there and is just helping. She had no clue on any information. After talking with the doctor she made me aware she had not scheduled him to be sent for cremation. I asked if I could pick him up and deliver him myself and was told yes, but they would not refund me for the cremation charge. Summary: I am filing this complaint because I believe the conduct described above constitutes professional negligence and a failure to meet the minimum standards of veterinary care in Wisconsin. For your information, there was a visible security camera in the procedure room where these events took place. I have requested my pet?s medical records but she has only provided me a generic summary of my visit with no detail. Thank you."

87. J.W. also provided a copy of an email sent to SVC on March 2, 2026. The email reads: *"Hi Jean, I am writing to formally request an itemized invoice and the full, unredacted medical records for my cat, Gilbert, regarding our visit on February 27th. To date, I have only received a summary, which is insufficient. Under Wisconsin Statute § 89.075, I have a legal right to access my pet's complete health care records, which must include documentation of all treatments, drugs administered, clinical findings, and informed consent, as required by Wis. Admin. Code § VE 1.52. Regarding the billing for this visit: I was informed by Jodi that you will not provide a refund for the portion of the cremation services I paid for. I am formally requesting an itemized bill emailed to me today that details exactly what I was charged for, including the specific portion covered by the foundation. Please provide the itemized invoice and the complete, unredacted medical records for Gilbert's visit by the end of the day today, March 2nd. If I do not receive these documents by the end of the day, I will be forced to initiate a chargeback dispute with my credit card company for services not rendered. I hope to resolve this immediately and await your response. Jessica Wright."*

88. On March 2, 2026, Carter requested the video footage mentioned in the complaint via email from the Respondent no later than March 9, 2026.

89. Carter received an email response from Respondent stating: "Yes i can send it if it was recording it has not been working the best."

90. Carter received a second email response from Respondent stating: "They chose to euthanize i offered surgery and they did not want to pursue surgery. I even offered to just charge for the euthanasia and then perform the surgery my expense

and then re home him to my farm. They were adamant to euthanize and i know i suggested they go to another hospital but they wanted to put him down".

91. On March 9, 2026, Carter received an email from Respondent stating that she could not provide the requested footage as the camera had not been recording on February 27, 2026.

92. Carter sent an email to the Respondent with an attached letter and copy of the complaint, requesting a response to the complaint, no later than March 24, 2026.

93. Carter sent an email to J.W. requesting a copy of the records provided to her by Respondent. J.W. sent me a two-page document which appears to be her cat's medical record.

94. February 27, 2026, medical history indicates that the Respondent saw the patient and the note states: "he was unblocked at er several weeks ago; acting loke blocked again jmedvm".

95. The medical history further indicates a radiographic study – 1 view, euthanasia, and private cremation with pawprint. A second note states: "still large bladder took 300 mls off of it"

96. On March 23, 2026, Respondent provided a response to the complaint. The response states: "When you call a clinic and make and appointment to bring your animal in for care that is "implied consent."'"

97. Response further states: "[J.W.] arrived with Gilbert at approximately 9:10 am and [Respondent] immediately checked his heartrate it was over 200 bpm, [Respondent] could feel his bladder that was enlarged and harder than a golf ball. An employee Hannah (1st day) chose to be a no show/no call that morning. [Respondent] called Kafryn Lieder (K.L.) whom has assisted me on several occasions to come and help me."

98. Response also states: "I immediately gave him 0.2ml of butorphanol, 0.2 ml of ketamine and 0.1 ml of acepromazine; Due to his apparent distress I did not take the time to pull out anesthesia forms or ask for signatures. I took him into the back and started him on 3/3 of isoflurane and O2; I put his head completely into the mask so nobody needed to hold it while Kafryn was on her way. When Kafryn (whom has experience helping) arrived she was the person holding the mask. I asked to run a cbc/chemistry and Jessica declined. Jessica had come by herself and she stayed in the exam room and reception; (she only came in back at the very end for euthanasia)".

99. The response states: "I then gave Gilbert 0.2 ml of Ketamine and 0.2 ml of

diazepam in the right front cephalic vein. I removed 350-mls of urine via cystocentesis to alleviate some of his pain. HR: 220 t: 100.6 rr 50 on intake; Q 15: HR 190, rr 40 no Q15 HR 160 rr 30, Q15 HR 120, rr 20; we then turned down the isoflurane to 2/ O2 still on 3; Gilbert rr continued to slow so we reduced the isoflurane to 1/ O2 to 2 and he then stabilized at 20 breaths per minute and a hr of 120."

100. The response further states: "He was completely out and [Respondent] started with Gilbert in ventral recumbency with his tail clipped forward, [Respondent] extruded the penis but could only get the catheter in the urethra 1 inch; [Respondent] pulled the prepuce to try and straighten out the urethra, [Respondent] used both air and water in the catheter. [Respondent] rotated him to dorsal recumbency, and then both lateral sides; [Respondent] was not having any success passing the catheter. [Respondent] used copious amounts of lubrication, and 3 different types of urinary catheters. (a slippery sam, a tomcat catheter and a mila which has a metal stylet.) [Respondent] went up front and spoke to [J.W.] to let her know [Respondent] was not successful and suggested they take him in for emergency PU surgery.(She declined) She [J.W.] did not know what that was so [Respondent] explained they make a cut in the penis and can usually make it so that they do not get blocked again. [Respondent has] not done that surgery and did not say [she] could do that surgery. Due to possible incontinence post PU [Respondent] offered to give [Gilbert] an outside home on [her] farm where he would have many buildings to go into and unlimited food and water. [Respondent] offered to open him up and attempt to pass the catheter from inside the bladder to the outside but [Respondent] stated "I am not certain it will be successful" [Respondent] recommended we start Gilbert on fluids, [J.W.] declined".

101. Response indicates that J.W. called her husband and they elected euthanasia.

102. When both owners were present, Gilbert was euthanized.

103. Response states: "[K.L.] paid 1/2 of their … bill that included the cost of the cremation. After euthanasia it is too emotional to sort out what any client wants from the crematory so we talk to them in a day or 2. … [Respondent] had not gotten his cremation form filled out as the crematory comes every Tues and [Respondent] only fill[s] them out the day prior to pick up. The person at my clinic the day they picked up his body has 10 years experience at other veterinary clinics but is not familiar with my protocols. After they picked up his body they asked for the cremation fee to be returned to them, [Respondent] stated [she] would refund [K.L.] whom donated to their bill. We did send the records with all the notes attached to [Respondent's] knowledge.".

104. On March 23, 2026, K.L., PhD, also submitted a response to the complaint

in support of Respondent. K.L.'s response indicates K.L. has known Respondent for 10 years and that Respondent is the veterinarian for K.L.'s animals. K.L. has volunteered at SVC from time to time over the past 10 years.

105. K.L.'s response states: "As a volunteer, I have helped with standard office appointments, surgeries, and emergencies, as well as cleaning exam rooms, answering the phone, and filling prescriptions. My volunteer work has **always** been under the supervision of a veterinarian."

106. K.L.'s response further states: "[Respondent] had asked me earlier in the week to help with some appointments in the morning on February 27, 2026, because one of the regular employees was not available. I arrived at the clinic around 9:30 a.m. When I arrived, [Respondent] was working with a male cat (Gilbert), who was a critical emergency case because of complete urinary blockage. One of his owners, [J.W.], had brought him in earlier that morning and had helped [Respondent] by monitoring his condition under anesthesia for a short time. [Respondent] told me that she had become uncomfortable with the situation and went to sit in the waiting room only a few minutes before I arrived."

107. K.L.'s response also states: "While I was there, I made sure the anesthesia mask was position properly, monitored Gilbert's respiration and perfusion, helped [Respondent] with positioning him, and handed her implements and supplies as needed. The cat was completely anesthetized and gave no indications of feeling pain. In fact, [Respondent] directed me to reduce the flow of anesthesia (isoflurane) when his respiration rate decreased somewhat. [Respondent] told me that she had given him an injection of a strong pain medication right away when he was brought in because he was clearly in pain. The mask fit over the cat's muzzle very well; I did not feel any symptoms of inhaling isoflurane during the hour or more that [Respondent] tried to save the cat."

108. K.L.'s response states: "The blockage was so extreme that [Respondent] could not catheterize him, despite trying many times and using different types of catheters. She tried dislodging the blockage multiple times by running either saline or air through each type of catheter, and repositioning the cat, but without success. In addition, [Respondent] X-rayed Gilbert's lower abdomen in case the blockage was large enough to be visible. It was not. She also flushed his bladder by injecting saline solution into the bladder and then extracting it. This approach did not remove the blockage, either."

109. K.L.'s response further states: "When it was clear that this was a refractory case, [Respondent] told [J.W.] that she was unable to remove the blockage and presented her with several options. First, she could take the cat back to the emergency clinic because they could have some additional tools to help alleviate the blockage. Second, [Respondent] could perform a penectomy and widen the urethra,

which would mean that Gilbert would almost certainly be incontinent. If they did not want to cover the cost of that surgery, but would let [Respondent] adopt the cat, she would care for him and keep him on her farm. Third, she could euthanize the cat. [Respondent] strongly advocated for either of the first two options, because she wanted the cat to live."

110. Respondent also provided a copy of Gilbert's medical record to the investigator. The record dated February 27, 2026 reads: "Office Call – DVM he was unblocked at er a week ago;either at VEG or VCA acting like blocked again jmedvm".

111. February 27, 2026 medical record further reads: "RAD1 Radiographic Study- 1 View. still large bladder took 400 mls off of it; I sedated with 0.4 mg/kg torb/ace and = amounts of ketamine then induced w/ 0.2 ml ket/val and had him masked w/ 3/3 iso/o2 monitored by Dr Kafryn Lieder checking vitals; I placed him in ventral recumbency and had his tail clipped forward I clipped and scrubbed the area; I extruded the penis and attempted to pass a catheter; I used a milan tomcat/ a slippery sam and another feline catheter to no success; I put his in dorsal recumbency and pulled his legs forward and pulled back the prepuce; no success passing the catheter; I had all 3 catheters lubed; I put him in lateral recumbency and still I was unable to pass the catheter; I contacted the O and stated he should be referred to an ER as I have not done a PU sx or I could open him like a cystotomy but there were no guarantees; The O stated they wanted him euthanized they would not consider any other options I tried over and over to get then to take then back to the clinic that originally unblocked him but they just wanted him put down jmdevd".

112. February 27, 2026, medical record also reads: "EUTHF Euthanasia Feline Gilbert was waking up so I had to give him another 0.4 ml of ket /val in the right cephalic prior to giving him 2 mls of euthanasia solution; He passed quietly".

113. February 27, 2026, medical record reads: "JME CRP325 Private Cremation with Pawprint 3-25# 3/19 2026 Addendum: O declined referral, blood work and fluids. O has taken to social media to try and destroy my business. I am afraid for myself, my family, my pets and my clinic due to her outlandish perception and lies about my care, I question her mental stability. Jessica does not possess the most basic animal husbandry skills to even care for a cat properly. They did not follow the other clinics recommendations of allowing them to keep Gilbert for 1-2 days to allow his urine to flow freely according to when I asked if he stayed overnight. jmedvm".

CONCLUSIONS OF LAW

114. The Veterinary Examining Board has jurisdiction in this matter pursuant to Wis. Stat. § 89.07 (2).

115. Since at least August of 2024, regarding 24 VET 107, based on the conduct described in the Findings of Fact, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § VE 1.58(7): *Violating or aiding and abetting the violation of any law or administrative rule or regulation substantially related to the practice of veterinary medicine,* by violating Wis. Stats. § 95.21(2)(a): *(2) Rabies vaccination required for dogs: (a) Requirement for vaccination. Except as provided in s. 174.054 or sub. (9) (d), the owner of a dog shall have the dog vaccinated against rabies by a veterinarian or, if a veterinarian is physically present at the location the vaccine is administered, by a veterinary technician, pursuant to s. 89.05 (2) (d), at no later than 5 months of age and revaccinated within one year after the initial vaccination. If the owner obtains the dog or brings the dog into this state after the dog has reached 5 months of age, the owner shall have the dog vaccinated against rabies within 30 days after the dog is obtained or brought into the state unless the dog has been vaccinated as evidenced by a current certificate of rabies vaccination from this state or another state. The owner of a dog shall have the dog revaccinated against rabies by a veterinarian or, if a veterinarian is physically present at the location the vaccine is administered, by a veterinary technician, pursuant to s. 89.05 (2) (d), before the date that the immunization expires as stated on the certificate of vaccination or, if no date is specified, within 3 years after the previous vaccination.*

a. SVC does not employ any CVTs.

b. D.G. and L.F. stated that unlicensed assistants administer rabies vaccinations and sign Respondent's name to rabies vaccination certificates when Respondent is not at the clinic. Unlicensed assistants administered a rabies vaccination to a dog "Remi" and signed her name to the vaccination certificate. See pars. 6.d and 7.e.iv.

c. The SVC appointment schedule for August 22, 2026, indicates Remi had a scheduled appointment at 9 a.m. Remi's medical record dated August 22, 2026, indicates a "tech office call" was charged and a rabies vaccination was administered. The record states "t 101.2 hr 110 Bright alert responsive; no significant findings on paw;". See pars. 15.d and 15.h.

d. On November 6, 2024, Carter received an email from staff member stating Respondent had made changes to records requested during the inspection on November 4, 2024. Staff member stated that Respondent had changed Remi's August 22, 2024, medical record to state that she was contacted via phone call and she was not; the entire appointment was performed by L.F. and D.G. See par 18.b

e. April 11, 2025, response states that assistants made a video call to Respondent during Remi's August 22, 2024, appointment. Assistants reported exam findings to Respondent. Response also states Respondent

visually examined Remi's paw during the video call and that Respondent prescribed Animax. Respondent instructed assistant to administer rabies and watched as the assistant did so. See par. 37.d

f. Response further states that prior to the complaint, Respondent "was unaware that Wis. Stat. § 95.21(2)(a) limits rabies administration to veterinarians and to CVTs when a veterinarian is physically present at the location where the vaccine is administered. See par. 34.d

g. Remi's medical record for August 22, 2024, provided by Respondent, states "t 101.2 hr 110 Bright alert responsive; no significant findings on paw; contacted dvm via phone". See par. 30.f

h. On May 14, 2025, Carter received an email from A.N., a former employee of SVC from March 2019 to January 2022. A.N. stated she "monitored multiple patients under anesthesia, administer [sic] rabies dozens of times and issued CVI's." See par. 46.a

i. A.N. also stated that Respondent made an offer of [re]employment to A.N. on May 2, 2025. According to A.N., Respondent "was talking about not coming in on May 3 [2025]... Due to there only being a rabies vaccine appointment that day, and [Respondent felt A.N.] could handle the rabies vaccine by [her]self." See par 46.e

116. Since at least August of 2024, regarding 24 VET 107 based on the conduct described in the Findings of Fact, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § VE 1.58(7): *Violating or aiding and abetting the violation of any law or administrative rule or regulation substantially related to the practice of veterinary medicine* by violating Wis. Admin. Code § ATCP 10.06(2): *Certificate of Veterinary Inspection. (2) Who may issue. An accredited veterinarian shall prepare and sign a certificate of veterinary inspection, except that a Wisconsin certified veterinarian shall prepare and sign a certificate issued in Wisconsin.*

a. On September 17, 2024, L.F. told Carter that Respondent was out of the office a total of two to three weeks during 2024. Unlicensed assistants saw patients and issued CVIs. Specifically, on August 22, 2024, unlicensed assistants examined a dog, Cabali, issued a CVI, and signed Respondent's name to the CVI. See pars. 7.e and 7.e.iii.

b. On November 5, 2024, Carter received the August 22, 2024, SVC appointment schedule indicating Cabali had an appointment at 11:30 a.m. as well as Cabali's medical record and CVI issued August 22, 2024. Cabali's medical record for August 22, 2024, states "BAR scared; t 101. hr 120 cvi issued jmedvm contacted via telephone". See pars. 15.d and 15.g.

c. On November 6, 2024, Carter received an email from staff member stating that Respondent made changes to the requested medical records, including Cabali's medical record. Staff member states that Respondent added notes for the CVI that she was contacted by telephone. Respondent was not in the clinic that day. See par. 18.a.

d. On December 10, 2024, Carter spoke with A.P., Cabali's foster provider. A.P. stated that on August 22, 2024, she and Cabali were taken to an exam room where D.G. performed an exam. A.P. waited in the waiting room and received a signed CVI. A.P. said she looked up a picture of Respondent and was "fairly confident" she had never seen her before. See par. 28.

e. April 11, 2025, response states that Cabali's appointment on August 22, 2024, was scheduled for a timeslot prior to Respondent's anticipated arrival. An assistant performed an exam and then called Respondent to report. Respondent determined that a CVI could be issued and asked the assistant to sign her name to the CVI. Respondent also provided a copy of Cabali's medical record with response. See pars. 30.d and 37.c

f. On May 14, 2025, Carter received an email from A.N., a former employee of SVC from March 2019 to January 2022. A.N. stated she "monitored multiple patients under anesthesia, administer [sic] rabies dozens of times and issued CVI's." See par. 46.a

117. Since at least August of 2024, regarding 24 VET 107, based on the conduct described in the Findings of Fact, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § VE 1.58(7): *Violating or aiding and abetting the violation of any law or administrative rule or regulation substantially related to the practice of veterinary medicine* by violating Wis. Admin. Code §§ ATCP 10.06(4)(i) and (j): *Certificate of Veterinary Inspection. (4) Contents. Except as required by other applicable provisions of law, a certificate of veterinary inspection related to a shipment of animals shall include all of the following information, which shall be verified by the issuing veterinarian: (i) The following statement, or one substantially similar: "I certify, as a veterinarian, that I have inspected the animals identified on this certificate and that the animals are not showing signs of contagious or infectious disease, except where noted. Vaccinations and test results are as indicated on the certificate. To the best of my knowledge, the animals identified on this certificate meet applicable federal and state of destination requirements. (j) The veterinarian's signature, date of signature, inspection date, and issue date.*

a. See pars. 99.a-f.

118. On August 22, 2024, regarding 24 VET 107, based on the conduct described

in the Findings of Fact, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § VE 1.58(7): *Violating or aiding and abetting the violation of any law or administrative rule or regulation substantially related to the practice of veterinary medicine* by violating Wis. Admin. Code § ATCP 16.16(2): *Certificate of veterinary inspection. (2) Who may issue. A certificate of veterinary inspection under sub. (1) shall be prepared and signed by a Wisconsin certified veterinarian described under s. ATCP 10.05, except that a certificate accompanying a dog imported into this state shall be issued by an accredited veterinarian, as defined under s. ATCP 10.01 (2).*

a. See pars. 99.a – f.

119. Since at least August of 2024, regarding 24 VET 107, based on the conduct described in the Findings of Fact, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § VE 1.58(21): *Failure to keep the veterinary facility and all equipment, including mobile units, in a clean and sanitary condition while practicing as a veterinarian.*

a. D.G. stated that Respondent placed unused suture material in a stainless-steel container with a lid, kept in the surgery room. The suture material and container were not autoclaved or otherwise sterilized at any point. See pars. 6.a and 7.a
b. On September 17, 2024, L.F. stated that she had observed flies in the surgery room, maggots in the trash, that trash is emptied every other day at most, that Respondent uses unsterilized tools for surgery if one is needed Respondent does not wear gloves for dentals, and that SVC does not have a working washer and dryer. See pars. 7.g – j.
c. On November 4, 2024, Carter conducted an unannounced inspection and found visibly soiled walls and surfaces, full garbage cans, a toothbrush used for dentals stored in an improper manner, and evidence that the washer and dryer may not be functional. See par. 10.
d. November 6, 2024, email from anonymous states Respondent doesn't clean the rectal thermometer after use. See par. 20.
e. Respondent's April 11, 2025, response states: "On the few occasions where suture material opened during a patient's surgery is not completely used up, the remainder is cold sterilized by soaking in chlorhexidine for 4-6 hours… [Respondent] will use the cold-sterilized suture material if an extra stitch or two is needed to complete closures for spay surgeries on barn cats." See par. 31.
    i. Storing cold-sterilized sutures in an unsterilized stainless steel container renders the sutures unsterile.
f. April 11, 2025, response further states: "SVC has a dryer, and both it and the washing machine function properly. Issues arise only when assistants attempt to use the machine improperly, as Goossen did on many occasions. For example, assistants sometimes overfill the drum and/or fail to remove feces from towels before placing them into the

washing machine. [Respondent] has had to retrain SVC assistants several times to remove feces before placing items in the washing machine and only filling 3/4 of the drum." See par. 38.

g. May 14, 2025, email from A.N. states she quit SVC because "lack of sterilization used during surgery was very concerning. Such as not wearing a gown, grabbing hemostats and scissors off the wall instead of opening another surgical pack. Seeing sweater sleeves dipping into open wounds and then charging clients when they come back with an infection. Starting the next surgeries before the surgical room could be properly turned over causing cross contamination." See par. 46.c.

121. Since at least August of 2024, regarding 24 VET 107, based on the conduct described in the Findings of Fact, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § 1.58(19): *Failure to maintain records as required by s. VE 1.52(2) and 1.52(4)(e).*

a. On September 4, 2024, D.G. stated that Respondent does not record the amounts of controlled substances on or dispensed to a patient in the medical record. See par. 6.b.

b. On September 17, 2024, L.F. stated Respondent does not consistently record the amounts of controlled substances used or dispensed in patients' medical records or the controlled substance log. L.F. provided a specific example of an in-home euthanasia performed on a cat, "Lucky" in which no dose of euthasol had been recorded in the medical record or the controlled substance log. See par. 7.c.

   i. On November 4, 2024, Carter reviewed controlled substances logs during the inspection. The log for Euthanasia solution had entries dated from June 30 [2024] to October 20 [2024]. There were no entries on September 11 [2024] and no entries for Lucky Schlimgen. See par. 11.

   ii. On November 5, 2024, Carter received a copy of Lucky's medical record. The entry for September 11, 2024, does not contain the amount of Euthasol administered. See par. 15.k

c. L.F. stated that Respondent does not create complete records for farm calls. L.F. provided a specific example of a certificate of veterinary inspection (CVI) issued to a horse, "Queso", whose medical record did not contain any exam findings on which to base the issuance of the CVI. See par. 7.d.

   i. On November 5, 2024, Carter received a copy of Queso's medical record The medical record dated September 28, 2023, indicates a CVI charge. The record does not contain exam findings. See par. 15.l.

d. On November 5, 2024, Carter received medical records for farm cat spay

and neuter surgeries: “Orange Kitten” Ranum, “Lewis” Donnell, “Winston” Donnell, and “Black” Meyer, do not contain the amounts of drugs prescribed, dispensed or administered, including strength or concentration, route of administration. All records indicate the patients’ owners were billed for “Farm Cat/Spay Package.” See par. 15.a

e. On November 5, 2024, Carter received medical records to verify controlled substance log entries reviewed at the inspection on November 4, 2024: “Lucy” O’Connell’s and “Coco” Raymond’s medical records do not contain individual dosages of controlled substances administered. Dosages of euthanasia solution for Lucy and butorphanol for Coco were recorded in the respective controlled substance logs. See par. 15.b.

f. On November 6, 2024, Carter received an email from staff member stating that Respondent had made changes to requested records for farm cat spay and neuters and records selected to verify controlled substance log entries. See par. 18.

g. L.F. stated that on September 6, 2024, Respondent attempted to give a dying dog, Bo Bradfield, 3L of IV (intravenous) fluid over 2.5 hours. See par. 7.k.
    i. On November 5, 2024, Carter received Bo Bradfield’s medical record. No exam findings are listed for the exploratory surgery. The records do not indicate a pre-surgical exam was performed, and there is no documentation of informed consent. See par. 15.m.
    ii. Respondent provided a response to L.F.’s allegations regarding Bo Bradfield. Response states, in pertinent part: “Because Bo was 92 lb. and almost 10% dehydrated, he had a 4-5L fluid deficit. [Respondent] administered 2L of fluids intravenously and 1L subcutaneously over the course of 2.5 hours. Provision of 3L of fluids was indicated and medically appropriate for the large deficit.” See pars. 39 and 40.
    iii. Respondent also provided a copy of Bo’s medical record along with the response. See par. 30.h.
    iv. The medical record does not contain any information about Bo’s dehydration level or how his level of dehydration level was determined. There are no exam findings listed for September 6, 2024, and the medical record does not contain sufficient information to justify the treatment (fluids) administered. See par. 41.
    v. Bo ultimately passed away after Respondent, according to the medical record, “spent 2 hours attempting to get him back” though the actions taken or medications administered in these two hours are not documented in the record.

h. On November 6, 2024, anonymous' email stated that an SVC patient, "Duke" Kleppe, "had a mass on its butt and if it wasn't wrapped, it would bleed a lot. [Respondent] was going to start surgery so she sedated the animal and unwrapped the bandage to take a look at it but got distracted by other things happening at the clinic for an hour. She did not wrap the dog back up and put him in a kennel, so he continued to bleed all over the treatment area." See par. 19.

    i. Anonymous also provided Duke's medical record, which indicates he underwent a mass removal at SVC on October 22, 2024, and a CBC was performed. There are no exam findings or any indication that a pre-surgical exam was performed. The record also lacks entries for history, present complaint, present illness, provisional diagnosis, a description of the surgical procedure, anesthesia monitoring notes, post-surgical exam notes, and a record of informed consent.

122. Since at least July of 2024, regarding 24 VET 107, based on the conduct described in the Findings of Fact, Respondent improperly delegated veterinary medical acts to unlicensed assistants as defined by Wis. Admin. Code § VE 1.44(2)(a): *Delegation of veterinary medical acts. (2) The following acts are limited to those holding a license under s. 89.06 (1), 89.06 (2m) (a), or 89.072, Stats.; a permit under s. VE 1.36, 1.38, or 1.40; or active status as a student at a college of veterinary medicine approved by the board, and may not be delegated to or performed by veterinary technicians or other persons not holding such license or permit: (a) Diagnosis and prognosis of animal diseases and conditions.*

a. On September 17, 2024, L.F. stated that Respondent was out of the office for two to three weeks during 2024, but that unlicensed assistants conducted patient appointments. See par. 7.e.
b. On November 4, 2024, Respondent told Carter that she had been out of the clinic for extended periods over the past year due to health issues. She broke her leg and was out from April 30 to June 1 for surgery and recovery but was available by phone and had instructed her employees, D.G. and L.F., to call her or use Zoom whenever necessary. Respondent further stated that she had also come into the clinic in a wheelchair and sat in the exam room door to do what work she could during this time.Respondent stated she was also out for another medical issue later in the year and instructed the employees again to call her or use Zoom whenever necessary. She did not receive any phone calls or Zoom calls. Employees had access to controlled substances when she was out. To her knowledge, phenobarbital was the only controlled substance dispensed. Respondent stated she knew D.G. and L.F. were cleaning ears and dispensing medications. Respondent stated that in hindsight, she should have just closed the clinic. See pars. 13-14.

c. On November 5, 2024, Carter received requested records from staff member via email. The email also noted that Respondent had not been in the clinic from August 19, 2024, to August 23, 2024. All appointments on those days were performed by assistants. See pars. 15 and 16.
d. On December 3, 2024, Respondent's attorney stated Respondent had been out of the office August 19, 2024, until August 21, 2024. See par. 22.
e. Carter reviewed SVC appointment schedules provided on November 5, 2024 (see pars. 15 and 25). Carter contacted the owners of animals on the appointment schedules for August 22, 2024, and August 23, 2024. None of the owners contacted saw or spoke with Respondent at their appointments. All owners stated the appointments were conducted by "technicians" (unlicensed assistants). See pars. 24, 26-28.
f. In a May 14, 2025, email, A.N. stated she "was expected to handle smaller appointments by [herself], such as ear infections, urinalysis, rabies and vaccine appointments along with cytopoint."See par. 46.b.
g. April 11, 2025, response states, regarding appointments conducted August 22, 2024, through August 24, 2024, appointments were scheduled for a time that Respondent wasn't in the clinic or didn't know about the appointment, in the cases of Maggie Dahm and Tots Botham. See par. 37.a-b.
h. On September 17, 2024, L.F. stated that on August 20, 2024 Maggie Dahm was examined by an assistant as the cat was shaking her head. The cat had a previous ear hematoma repair surgery done by Respondent. See par. 7.e.i.
    i. Maggie's medical record, provided by staff on November 6, 2024, indicates the cat had a tech office call on August 20, 2024. Notes from this appointment state "looked at animal stable nothing done sent home;" Respondent's initials are in the "By" column but the "Description" lists "Tech office call". See par. 15.f
    ii. April 11, 2024 response states, in pertinent part: "[Respondent] does not recall receiving a video call from the assistant during that [Maggie] appointment, such that a virtual examination would be permissible under Wis. Admin. Code § VE 1.50(4). That fact, along with the lack of detail in the patient record, leads Respondent to believe that this was another instance of an SVC assistant conducting evaluating a patient without her knowledge or authorization." See par. 37.a

i. Based on the August 22, 2024, appointment schedule, assistants performed a new puppy wellness exam for "Tots" Botham. See par. 15.d. An unlicensed assistant examined SVC patient Tots Botham and made an assessment of the dog's condition to determine whether the dog was healthy enough for vaccination.

i. On the medical record provided by SVS staff on November 5, 2024, Respondent's initials are listed in the "By" column. See par 15.i.

ii. On December 5, 2024, Carter received an email from P.B, Tots' owner, stating that he had not seen Respondent during Tot's appointment on August 22, 2024, and that a "vet tech" had administered the vaccine. See par. 24.a.

iii. April 11, 2025 response states, "According to the patient record, owner [P.T.] presented Tots to SVC on August 22, 2024. The patient record does not identify the presenting complaint or whether Tots was physically examined. [Respondent] was in the clinic that day, but was not aware of or informed about Tots' appointment. Therefore, [Respondent] suspects that the visit occurred either before she arrived at SVC that morning or after she left for the day." See par. 37.b.

j. Based on the August 23, 2024, appointment schedule, L.A. had an at 10:30 a.m. for her dog, Mazie. The medical history also indicated that Sucralfate and Loperamide were dispensed. See par. 25.

i. In a December 11, 2024, email, L.A. stated she had scheduled the appointment that morning as Mazie was licking her paws and experiencing soft stools. Respondent was not there that day and there was no video call, to L.A.'s knowledge, with Respondent. Assistants performed a fecal as well as the entire appointment.

i. D.G. and L.F performed Mazie's appointment for symptoms of illness, made a diagnosis and prognosis, and dispensed medication.

ii. L.A. does not recall a video call with Respondent during Mazie's appointment. See par. 42.

k. Based on the August 23, 2024, appointment schedule, A.N. had an appointment at 9:00 a.m. for her cat, Ivar. See par. 25.

i. The medical history, previously provided by anonymous in an email sent December 4, 2025, states A.N. was charged for a tech office call. See par. 25.

ii. On May 14, 2025, A.N. stated Ivar's appointment was entirely performed by D.G., who conducted testing, discussed findings, and dispensed medications. A.N. stated she did see Respondent at the appointment – she popped her head into the exam room. See par. 43.

iii. A.N.'s statement in par. 103.k.ii proves that Respondent was

aware of Ivar's appointment and allowed D.G. to conduct the appointment.

l. On May 14, 2025, A.N. also stated that D.G. and another assistant conducted an appointment for Ivar on July 1, 2025. See par. 44.
    i. Ivar's medical history indicates Ivar received the following care at SVC: Radiographic Study -1 view, Tech office call, culture and sensitivity, T4 thyroid test, CBC, TMS Sulfamethoxazole/Trimethroprim 960m. See par. 25.

m. On September 17, 2024, L.F. stated that on August 22, 2024, Remi Hoffmaster had an appointment with a veterinary assistant, who performed an examination of the dog's paw, administered a rabies vaccination, and dispensed Animax. See par. 7.e.iv.
    i. Remi's medical record provided by staff at SVC on November 5, 2024, states the following, in pertinent part, for the entry dated August 22, 2024: "t 101.2 hr 110 Bright alert responsive; no significant findings on paw;" See par. 15.h.
    ii. In an email received on November 6, 2024, SVC staff indicated that Respondent added her initials to Remi's medical record under the "By" column, though the entire appointment was performed by veterinary assistants [L.F.] and [D.G.]. See par. 18.b.
    iii. On December 6, 2024, Carter spoke to Remi's owner, D.H. She stated she had not seen Respondent at the August 22, 2024 appointment. See par. 27.
    iv. April 11, 2025 response states: "An assistant measured Remi's vital signs, which were normal, and reported the information to [Respondent] via a video call. [D.H.] told Dr. [Respondent] that she was concerned there had been some trauma to one of Remi's paws. The assistant held the camera so that [Respondent] could visually examine Remi and inspect the paw. [Respondent] noted only minor irritation on Remi's paw and prescribed Animax ointment. [Respondent] told [D.H.]that Remi was healthy and able to receive vaccinations. [Respondent] instructed the assistant to administer rabies and distemper combination vaccines and watched as the assistant did so." See par. 37.d
    v. Remi's medical record provided by Respondent with response documents on April 11, 2025 states the following, in pertinent part, for the entry dated August 22, 2024: "t 101.2 hr 110 Bright alert responsive; no significant findings on paw; contacted dvm via phone". See par. 30.f

123. Since at least July of 2024, regarding 24 VET 107, based on the conduct detailed in the Findings of Fact, Respondent improperly delegated veterinary medical acts to unlicensed assistants as defined by Wis. Admin. Code § VE 1.44(2)(a): *Delegation of veterinary medical acts. (2) The following acts are limited to those holding a license under s. 89.06 (1), 89.06 (2m) (a), or 89.072, Stats.; a permit under s. VE 1.36, 1.38, or 1.40; or active status as a student at a college of veterinary medicine approved by the board, and may not be delegated to or performed by veterinary technicians or other persons not holding such license or permit: (b) Prescribing of drugs, medicines, treatments and appliances.*

a. See pars. 103.a – f.
b. See pars. 103.j - m.

124. Since at least March of 2019, regarding 24 VET 107 and 26 VET 022, based on the conduct described in the Findings of Fact, Respondent improperly delegated veterinary medical acts as defined by Wis. Admin. Code § VE 1.44(6)(a): *Veterinarians may delegate to certified veterinary technicians the provision of the following veterinary medical services under the supervision of the veterinarian when the veterinarian is personally present on the premises where the services are provided: (a) Administration of local or general anesthesia, including induction and monitoring.*

a. On March 17, 2024, L.F. told Carter that unlicensed assistants intubate and monitor patients during surgery and adjust isoflurane as needed based on their assessments with only limited direction from Respondent. See par. 7.b.
b. On September 30, 2024, D.G. provided a written statement detailing his job duties, which states, in pertinent part: "Doctor arrives around 9AM- If no early morning doctor appointments; administer pre-medication to surgical patient. Prepare induction medications (Ketamine and Diazepam). Administer induction medications. If older patient or dental patient I was instructed to place and ET tube. Shave and prep surgical sites. During surgeries- Monitor general anesthesia (lsoflurane gas), monitor respiration, heart rate, and temperature during surgery." See par. 8.
c. April 11, 2025 response states: "[Respondent] occasionally asks an assistant to intubate a patient under her direct supervision… [Respondent] is also physically present in the operating room and standing right next to the assistant when the patient is intubated. Intubation is not the diagnosis or prognosis of disease or the prescription of drugs or treatments…It is not surgery since patient tissue is not penetrated or severed…Intubation is not a veterinary medical act that may only be delegated to CVTs…Therefore, intubation is a nonsurgical treatment that may be performed by an unlicensed assistant under the supervision of a veterinarian that is personally present on the premises where intubation is performed… Because [Respondent] is not only on the premises but maintains direct supervision of the assistant that

intubates a patient, [Respondent's] delegation of that act is lawful." See par. 36.a

d. Response further states: "[Respondent] monitors a patient's anesthesia herself during surgery; assistants provide appropriate help as requested by [Respondent] so that she does not have to break the sterile field. Assistants thus sometimes observe anesthesia parameters simultaneously with [Respondent]. If some aspect of the anesthesia needs to be adjusted, [Respondent] directs the surgical assistant(s) to take the exact action needed. [Respondent] does not allow unlicensed assistants to unilaterally adjust anesthesia parameters. [Respondent] is not aware of any patient experiencing adverse events or complications as the result of an unlicensed assistant, as opposed to a CVT, alerting her to a change in patient physiologic variables or adjusting anesthesia parameters pursuant her specific direction. While it may be best practice to have a CVT monitor anesthesia while [Respondent] operates, [Respondent] has not found suitable applicants for hire despite actively searching. Wisconsin Statutes and Chapter VE of the Wisconsin Administrative Code do not define "administer anesthesia," "induce anesthesia," or "monitor anesthesia." It is [Respondent's] position that neither situation discussed *supra* – allowing an experienced assistant to intubate a patient under [Respondent's] direct supervision and guidance, and to provide supplemental observation of a patient's vital parameters along with [Respondent]– contravenes Wis. Admin. Code § VE 1.44(6)(a)." See par. 36.b
e. In a May 14, 2025, email, A.N. stated, in pertinent part, she: "monitored multiple patients under anesthesia, administer [sic] rabies dozens of times and issued CVI's." See par. 46.a.

(26 VET 022)

f. On February 27, 2026, J.W. states she held the anesthesia mask on Gilbert while Respondent was attempting to unblock the cat. J.W. states she could smell and taste the anesthetic agent . See par. 86.
    i. K.L. stated in her response that J.W. had helped Respondent by monitoring Gilbert's condition under anesthesia for a short time. See par. 106.

g. K.L.'s February 27, 2026, response states that in her time as a volunteer at SVC she has helped with surgeries. See par. 105.

h. K.L.'s response also states that on February 27, 2026, she positioned the anesthesia mask and monitored Gilbert's respiration and perfusion. See par. 107.
    i. Respondent's response states on February 27, 2026 she called K.L. "[who] assisted Respondent on several occasions". Respondent also stated "when K.L. ([who] has experience helping) arrived she was the person holding the mask." See pars. 97 – 98.
    ii. K.L.'s response states she has a PhD in Biochemistry. K.L. is not a licensed veterinarian or CVT.

125. Since at least August of 2024, regarding 24 VET 107, 24 VET 146, 25 VET 081, and 26 VET 022, as described in the Findings of Fact, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § VE 1.58(2): *Conduct in the practice of veterinary medicine which evidences a lack of knowledge or ability to apply professional principles or skills.*

(24 VET 107)

a. Respondent altered medical records for Remi:
    i. See pars. 97.b-g, 27, 30.f, and 37.d.
b. Respondent stores sutures in an unsterile manner which renders the sutures unsterile. See pars. 6a,7.a, 10.f.
c. Allegations by staff include failing to keep the clinic at a comfortable ambient temperature during clinic hours, which may adversely affect the recovery of surgical patients. Respondent's response states the air conditioning is turned on when temperature reach or exceed 90 degrees F. See par. 33.f.
d. In a December 16, 2024, email, anonymous stated that no warming equipment is used during or after surgery. In colder months, patients are wrapped in blankets but they don't always remain in the blankets. See par. 29.b.
e. Respondent knowingly allowed unlicensed assistants to conduct appointments while she was out of the clinic from August 19, 2024, to August 23, 2024, and on other occasions as well. Respondent told Carter she knew D.G. and L.F. were conducting appointments. See par.14. Based on A.N.'s description of Ivar's appointment on August 23, 2024, Respondent was aware that D.G. had conducted an appointment. See par. 43.
    i. The veterinarian is responsible for the actions of clinic staff. As a Wisconsin licensed veterinarian, Respondent is responsible for knowing the regulations which apply to the practice of veterinary medicine in Wisconsin, and if Respondent did not know or was unsure, is responsible for consulting the applicable administrative code or reaching out to the Board for clarification.

ii. Unlicensed assistants conducted appointments in which they made diagnoses and prognoses of animal diseases and conditions and prescribed drugs, medicines, treatments and appliances, in violation of Wis. Admin. Code §§ VE 1.44(2)(a) and (b). See pars. 103 and 104.

iii. Unlicensed assistants administered rabies vaccinations and signed Respondent's name to rabies vaccination certificates in violation of Wis. Stat. § 95.21(2)(a). See par. 97.

iv. Unlicensed assistants issued CVIs and signed Respondent's name to CVIs in violation of Wis. Admin. Code §§ ATCP 10.06(2), (4)(i), and (4)(j) and Wis. Admin. Code § 16.16(2). See pars. 98-100.

v. Unlicensed assistants administered local and general anesthesia, induced general anesthesia, and monitored patients under local or general anesthesia, in violation of Wis. Admin. Code § VE 1.44(6)(a). See par. 105.

(24 VET 146)

f. On February 6, 2024, Respondent exhibited a lack of professional knowledge and skill by failing to remove the entire ovary during a c-section. See pars. 47,52, and 54.

i. The incision made for a c-section is sufficiently large to visualize the ovaries.

ii. Leaving remnants of ovary behind after a c-section is not a common occurrence.

(25 VET 081)

g. Respondent altered medical records for KitKat:

ii. See pars. 66-67, 77.

h. Respondent exhibited a lack of professional knowledge and skill by the following actions:

i. Response states Respondent "carefully reviewed VEG records" prior to examining KitKat. The SVC medical record states that the "0.1 increase of BUN [was] not a concern" but the VEG records indicate BUN was normal (see par. 60). Respondent did not review, or did not understand, the medical notes from VEG. See pars. 66, 84.

ii. Response further states that Respondent thinks the cat may have aspirated Clavamox and then presented with pneumonia. Aspiration pneumonia does not develop and present within two (2) hours. See par. 83.

(26 VET 022)

i. Respondent exhibited a lack of professional principles by not providing pain medication and sedation prior to performing a procedure likely to cause distress, as demonstrated by the content of the medical record.
    i. February 27, 2026, medical record indicates radiographs and cystocentesis performed prior to any medication being administered, in contrast with Respondent's response. The record states: ""RAD1 Radiographic Study- 1 View. still large bladder took 400 mls off of it; I sedated with 0.4 mg/kg torb/ace and = amounts of ketamine then induced w/ 0.2 ml ket/val…". See par. 112.
    ii. J.W. states, "[Respondent] attempted to catheterize my cat while he was clearly in distress and responsive, despite the anesthesia." See par. 86.
    iii. Respondent's response states: "I immediately gave him 0.2ml of butorphanol, 0.2 ml of ketamine and 0.1 ml of acepromazine; See par. 98.

126. On August 22, 2024, regarding 24 VET 107, by the conduct described in the Findings of Fact, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § VE 1.58(3)(b): *Unprofessional conduct by a veterinarian is prohibited. Unprofessional conduct includes: (3) Fraud in the practice of veterinary medicine, including any of the following: (b) The making of false claims regarding testing, inspecting, reporting or issuing of inter–state, intra–state or export health certificates.*

a. Respondent falsely certified and signed an intra-state health certificate (CVI) for a dog, Cabali. According to staff, unlicensed assistants issued and signed CVIs on multiple occasions.
    iv. See pars. 98-100.

127. On December 3, 2024, April 11, 2025, and March 23, 2026, regarding 24 VET 107 and 26 VET 022, by the conduct described in the Findings of Fact, Respondent engaged in unprofessional conduct as defined by Wis. Stat. § 89.07(1)(a): *In this section, unprofessional conduct includes, but is not limited to: (a) Making any materially false statement or giving any materially false information in connection with an application for a license or for renewal or reinstatement of a license or in making a report to the examining board.*

(24 VET 107)

a. Respondent falsely told Carter, the Board's representative, in an email sent by her legal counsel on December 3, 2024, that she had been out of the clinic from August 19, 2024, to August 21, 2024. See par. 22.

i. D.G., L.F., and other SVS staff members state Respondent was out of the clinic from August 19, 2024, to August 23, 2024.
ii. According to the Starlight Veterinary Services website (http://www.starlightvet.com/) clinic hours are 7:30 a.m. to 5:30 p.m., Monday through Friday.
iii. The August 22, 2024, SVS schedule shows all surgical appointments were rescheduled, no farm or house calls are listed on the schedule, and six (6) appointments for cats and dogs were scheduled beginning at 9 a.m. and ending at 4:30 p.m. See par. 25.a
iv. August 23, 2024, schedule shows all surgical appointments were rescheduled, one house call was rescheduled, and 10 appointments for cats and dogs were scheduled beginning at 8:30 a.m. and ending at 12:30 p.m. See par. 25.a.
v. December 5, 2024, email, P.T. stated he did not see Respondent at the clinic during his dog Tots' appointment [at 9 a.m.] on August 22, 2024. See par. 24.
vi. During a December 4, 2024, phone conversation, D.H. stated she did not see Respondent at SVS during her dog Remi's appointment [at 9:30 a.m.] on August 22, 2024. See par. 27.
vii. December 10, 2024, email from A.P., foster provider to Fetch Rescue dog Cabali, stated she did not see Respondent at Cabali's appointment [at 11:30 a.m.] on August 22, 2024. See par. 28.
viii. December 11, 2024, email from L.A. stated she did not see Respondent at SVS during her dog Mazie's appointment at 10:30 a.m. on August 23, 2024. See par. 26.
ix. May 7, 2025, email from L.A. states there was also no video call with Respondent during Mazie's appointment, at least nothing that was shared with her. See par. 42.
x. May 14, 2025, email from A.N. stated that D.G. performed the entire appointment for her cat, Ivar, [at 9 a.m.] on August 23, 2024. A.N. said that Respondent was not at SVS when she arrived, but Respondent popped her head into the room at some point during the appointment and asked what was going on with her cat and then was gone. Respondent did not discuss the appointment findings and was not present during any of the discussion. A.N. stated she does not know if Respondent left SVS or just left the room. See par. 43.

b. Response to the Board falsely states that Respondent conducted a telehealth appointment for Remi. Respondent altered Remi's medical record with a false statement.
i. Based on preliminary investigation interviews, on August 22, 2024, a dog, Remi Hoffmaster, had an appointment with a

veterinary assistant, who performed an examination of the dog's paw, administered a rabies vaccination, and dispensed Animax.

ii. D.G. and other SVS staff state Respondent was not in the in the clinic the week of August 19, 2024 to August 23, 2024.

iii. On November 4, 2024, Respondent told Carter that she had instructed D.G. and L.F. to call her or use Zoom whenever necessary. She did not receive any phone calls or Zoom calls. Respondent stated she knew D.G. and L.F. were cleaning ears and dispensing medications.

iv. Remi's medical record provided by staff at SVC on November 5, 2024 states the following, in pertinent part, for the entry dated August 22, 2024: "t 101.2 hr 110 Bright alert responsive; no significant findings on paw;" and also indicates that Animax Ointment was dispensed.

v. On November 5, 2024, Carter received a text from SVS staff stating: "I would also like to let you know that doc has been making changes to records from the list you gave me yesterday."

vi. In an email received on November 6, 2024, SVC staff states that Respondent added her initials to Remi's medical record under the "By" column, though the entire appointment was performed by veterinary assistants L.F. and D.G.

vii. On December 6, 2024, Carter spoke to Remi's owner, D.H. She stated she had not seen Respondent at the August 22, 2024, appointment.

viii. April 11, 2025, response states: "An assistant measured Remi's vital signs, which were normal, and reported the information to [Respondent] via a video call. [D.H.] told [Respondent] that she was concerned there had been some trauma to one of Remi's paws. The assistant held the camera so that [Respondent] could visually examine Remi and inspect the paw. [Respondent] noted only minor irritation on Remi's paw and prescribed Animax ointment. [Respondent] told [D.H.] that Remi was healthy and able to receive vaccinations. [Respondent] instructed the assistant to administer rabies and distemper combination vaccines and watched as the assistant did so."

ix. Remi's medical record provided by Respondent with response documents on April 11, 2025, states the following, in pertinent part, for the entry dated 8/22/2024: "t 101.2 hr 110 Bright alert responsive; no significant findings on paw; contacted dvm via phone".

c. Response falsely states that after receiving the complaint [27 VET 104], Respondent administers all rabies vaccines herself.
    i. April 11, 2025 response states: "Before receiving this complaint, Dr. Elmer was unaware that Wis. Stat. § 95.21(2)(a) limits rabies administration to veterinarians and to CVTs when a veterinarian is physically present at the location where the vaccine is administered. Dr. Elmer was also previously unaware that under Wis. Admin. Code § VE 1.44(8)(a), unlicensed assistants can administer vaccines only when the veterinarian is personally present on the premises where the vaccine is administered. Dr. Elmer acknowledges that her previous practice of delegating rabies vaccine administration to assistants under her direct supervision and of delegating other vaccine administration to assistants under her direct telehealth supervision were not in line state with law. Those practices have ceased. **Now, Dr. Elmer now administers all rabies vaccines herself** and trained SVC staff to administer other vaccines only be when she is at the clinic." See pars. 34.d-e.
    ii. A.N. states that on May 2, 2025, Respondent was talking about not coming on Saturday, May 3, 2025, "Due to there only being a rabies vaccine appointment that day, and I [A.N.] could handle the rabies vaccine by myself." See par. 46.e.

(26 VET 022)

d. Respondent falsely states that J.W. did not enter the room or assist during Gilbert's treatment on February 27, 2026.
    i. J.W. states that on February 27, 2026, that after arriving, "I was immediately taken to the procedure room … [Respondent] began administering treatments and procedures … During the procedure, the veterinarian required me "a non-medical client" to hold the anesthesia induction mask on my cat's face." See par. 86.
    ii. March 23, 2026, response states: "[J.W.] had come by herself and she stayed in the exam room and reception; (she only came in back at the very end for euthanasia)". See par. 98.
    iii. K.L.'s March 23, 2026, response states: "One of [Gilbert's] owners, [J.W.], had brought him in earlier that morning and had helped [Respondent] by monitoring his condition under anesthesia for a short time." See par. 106.

128. On February 27, 2026, regarding 26 VET 022, by the conduct described in the Findings of Fact, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § VE 1.58(4): *Gross, serious, or grave negligence, as compared to less serious or more ordinary acts of negligence, in the practice of veterinary medicine.*

a. Respondent exposed J.W. to anesthesia gas, exhibiting conduct potentially endangering public health, safety or welfare. See pars. 86 and 98.

129. On February 27, 2026, regarding 26 VET 022, by the conduct described in the Findings of Fact, Respondent engaged in unprofessional conduct as defined by Wis. Admin. Code § VE 1.58(27): *Failure to inform a client prior to treatment of the diagnostic and treatment options consistent with the veterinary profession's standard of care, meaning diagnostic procedures and modes of treatment considered by the veterinary profession to be within the scope of current, acceptable veterinary medical practice, and the associated benefits and risks of those options.*

a. Respondent failed to discuss treatment and diagnostic options, or the risks of surgery prior to administering anesthesia and attempting to perform surgery.
b. The records do not contain documented informed consent. See pars. 86, 94-95.

130. Through the conduct described in Findings of Fact, Respondent has engaged in conduct such that the public health, safety or welfare imperatively requires emergency suspension of Respondent's license. Wis. Admin. Code § VE 3.62(3).

131. There is sufficient nexus between the conduct and Respondent's fitness to practice veterinary medicine.

ORDER OF SUMMARY SUSPENSION

132. Respondent's license to practice veterinary medicine issued by Wisconsin Veterinary Examining Board to Jean M. Elmer, D.V.M., license number 404991, is summarily SUSPENDED, effective immediately.

133. The suspension order is in effect and continues until the effective date of a Final Decision and Order (FDO) issued in the disciplinary proceedings against the Respondent, unless otherwise ordered by the Board. Wis. Admin. Code § VE 3.62(4).

134. Upon Respondent's request, this summary suspension order may be stayed by the case advisor at the case advisor's discretion, but only after Respondent has signed a stipulation to resolve the matter via an FDO as presented by the Board. This paragraph does not require the case advisor to stay the suspension. If the suspension order is stayed, the case advisor may remove the stay at any time at the case advisor's discretion until the FDO has been signed by the board.

135. Respondent may request a hearing at any time to show cause why the summary suspension or limitation order should not be continued. Wis. Admin. Code § VE 3.62(5). Such request shall be filed with the Board at the following address:

WI DATCP, Division of Animal Health
Attn: VEB
2811 Agriculture Drive
P.O. Box 8911
Madison, WI 53708-8911

136. A hearing to show cause shall be scheduled for hearing on a date within 20 days of receipt by the Board of Respondent's request for hearing, unless a later time is requested by or agreed to by the Respondent. Wis. Admin. Code § VE 3.62(6).

137. A copy of this order shall be served upon Respondent by mail or by email if agreed to by Respondent or Respondent's attorney. Wis. Admin. Code § VE 3.64.

FOR WISCONSIN VETERINARY EXAMINING BOARD:

By: Alan Holter, D.V.M. Alan Holter, D.V.M. (Apr 14, 2026 14:26:34 CDT) Apr 14, 2026
Date

Print name: Alan Holter, D.V.M.
A Member of the Board